The Future of the Hospitals

Presidential Address delivered before the Northern Ireland Branch of the British Medical Association

By FRANK P. MONTGOMERY, M.B., D.M.R.

I MAKE no apology for choosing as the subject of my address to you to-day "T Future of the Hospitals." All thinking members of the profession realise t some form of National Health planning for the future is essential, and that whate system is evolved, it must be based on a reorganised National Hospital Service.

Let us look for a moment at the development of hospitals. Apart from the t famous religious foundations of St. Bartholomew and St. Thomas in Lond which managed to survive the destruction of the Reformation, the modern hospit as we know them date back little more than two hundred years. Thomas Guy, t founder of the hospital bearing his name, was one of the first philanthropists found a hospital, which was opened in 1725. It would be unfair, however, to gi Guy and his immediate successors all the credit for the endowment of a pub hospital at their own expense. This honour strictly belongs to Ireland, where n only was the general public more interested in the health of the people, but t Irish Parliament, unlike the English Parliament, passed special measures f hospital purposes. The actual pioneer was Dr. Richard Steevens of Dublin, w bequeathed at his death in 1710, real estate to the value of £600 a year for t establishment and endowment of a hospital "for the relief and maintenance curable poor people." This phrase is significant, because most of what we called general hospitals always excluded "incurables," and here again Ireland l the way. The first hospital for incurables was founded in Fleet Street, Dubli in 1744.

Dr. Steevens' bequest did not become operative until the death of his siste and the hospital was not therefore opened until 1731. In 1720 the people of Cor inspired by Dr. Steevens' munificence, founded an infirmary by public subscriptio

Jervis Street Hospital was founded in Dublin in 1728, thanks to the efforts several prominent medical men, and the year after the opening of Steeven Hospital, another benefactress gave her name to Mercer's Hospital, so th hospital-founding might be said to have been a general movement, with Dub and London pre-eminent.

The solitary example of a voluntary hospital which was directly due to t initiative of a medical corporation is supplied by Edinburgh, in which city t scheme of supplying the sick with advice and treatment free of expense had be adopted by the College of Physicians in 1682. In 1726, under the auspices of t College, a subscription was raised for the provision of a public infirmary—whi was opened in 1729.

And what of Northern Ireland? In 1765 the Irish Parliament established the county infirmaries by direct act. Under this Act the Grand Jury of each county was allowed to found a county infirmary and to pay towards its upkeep sums not exceeding seven hundred pounds a year, with one hundred pounds a year and other advantages to the surgeon.

This Act, according to Surgeon-General Evatt, who paid a visit of inspection to Ireland in 1903 as Special Commissioner for the British Medical Association, is regarded as one passed in the interests of the landlords. By it they were enabled to form a hospital for their bailiffs, game-keepers, and employees. They succeeded, however, in placing in every Irish county an efficient medical man receiving a grant from the State. This infirmary surgeon, with an income of £250 a year all told from the State funds, did not deal primarily with the necessitous poor, but was rather a physician to the landlords and their families. There are six of these County Infirmaries to-day in Northern Ireland: at Lisburn, Derry, Omagh, Downpatrick, Armagh, and Enniskillen.

The next step was the establishment of the Poor-Law System. Its watchwords were "abolish outdoor relief," "all paupers into the workhouse," and "all sick poor into the workhouse infirmary." In theory the doctor was appointed to the newly-constructed workhouse infirmary, in practice he was the doctor of the country town receiving a State salary and therefore able to a certain extent to survive in Irish medical practice, with its unending distance factor always awaiting solution by some help from national sources.

Over the door of all Irish workhouses is the date 1841, just one hundred years old, the year which marked the introduction of one of the most unpopular institutions in Ireland.

To counteract the lack of State support for hospitalisation, private charity came to the rescue, and during the eighteenth and nineteenth centuries many voluntary hospitals were founded and endowed by public subscription and private charity.

The eighteenth century had been chiefly characterised by the rise of the general hospital movement. The nineteenth was to be characterised by the progress of the specialist movement; while the chief characteristic of the twentieth century is now the belated but definite recognition by the State of its duties in anticipating disease by the employment of preventive hygiene.

While the State has been parsimonious to the point of folly in its support of the hospitals, the public has been generous to a degree which has amazed all visitors to this country. While Government has made provision for infectious diseases, mental diseases, and venereal diseases, it has never, except through its workhouses, attempted to deal with the ordinary medical and surgical cases requiring hospital treatment until twenty years ago. As a result, the main hospital accommodation up to 1920 was provided by voluntary hospitals, supported by the generosity of the public.

Under the Local Government Act of 1898, Ireland, authority was granted for the conversion of poor-law institutions into district hospitals for the treatment of

all cases within the area. The powers conferred under this Act were not utili until the end of the last war, and then Strabane, Lisburn, and Antrim Poor-L Infirmaries were converted into up-to-date district hospitals, in rapid successi Since that time nearly all similar institutions have been converted into mod hospitals, except in some towns where a county infirmary already existed. authorities in Northern Ireland are to be congratulated on taking the advice their medical advisers to rebuild all the old workhouses rather than adapt th without much structural alteration. As a result, Northern Ireland possesses a ch of district hospitals which are fully modern and fully equipped for almost ev type of general and specialised work. These hospitals are administered committees of the local boards of guardians, together with a few co-opted membe and are a charge on the rates. All of them have private and semi-private war and everyone in the area has a right of admission, subject to paying the cost maintenance, if able to do so. Had it not been for the existence of these distr hospitals at the beginning of the war, the disposal of air-raid casualties outs the Belfast area would have been well-nigh impossible.

The Six-County infirmaries are now in fact voluntary hospitals, though they subsidised by grants from the County Councils, with representation on the boar of management. The rest of the funds are raised by voluntary effort and payment from the patients.

There are also in Northern Ireland a number of cottage hospitals, many of th very well managed and efficiently run.

The total beds for ordinary medical and surgical cases in Northern Ireland about 5,300, or 1 for every 246 people, a dangerously low level of hospit accommodation.

War-time developments are provoking an extraordinary amount of discussi amongst doctors and all who work in the health services as to the purpose, scop and organisation of the medical services. Numerous groups to discuss post-w planning have come into existence, the most important of which is the Medic Planning Commission, composed of medical men representing all the major medic interests and set up on the initiative of the British Medical Association. Th British Hospitals Association, Political and Economic Planning, the Nuffie Provincial Hospitals Trust, and the Socialist Medical Organisation, are all workin out plans for the general reorganisation of the health services, including, of cours hospital services. So far, opinion is generally united on only one point, as far the hospitals are concerned, viz., that post-war hospitals and specialist servic must be controlled and planned on a regional basis. But how the hospital regio are to be planned, what type of regional hospital authority is required, in wh way voluntary and public hospitals are to fit into the regional scheme, are sti undecided issues.

Let us consider briefly some of the plans and recommendations which have bee put forward for the future organisation of the hospital services.

BRITISH MEDICAL ASSOCIATION.

HOSPITAL POLICY. *Sub-Appendix.*

(1) *Social and Scientific Changes.*

Everyone who has given serious consideration to hospital problems will be aware of two fundamental changes which have taken place in recent years. The first is a change brought about by social and scientific factors, the second one is imposed by legislation.

All who have watched the evolution of the voluntary hospital system in the past thirty years have noticed the striking change in the clientele appearing for treatment. Before the last war, the hospitals were treating the charitable poor, for whom they were built and endowed. To-day it is rare to see the poor and needy in our wards or out-patient departments, while the facilities of the hospitals are available to practically the whole community. With this widening in the scope of the hospital service there has also come a change in the type of service given. Whereas the "sick poor" looked to the hospital for any type of medical attention which they needed, general as well as specialist, the modern hospital is mainly concerned with the provision of consultant and specialist facilities.

Not the least important cause of this change is the elaborate nature of modern scientific methods, and the increasing art of their practical application. Many of the most modern and elaborate methods of diagnosis and treatment cannot be employed to best advantage except within the walls of a hospital. Moreover, they are expensive and can only be used economically when employed on a large scale.

As the community has come to expect a complete medical service, so the hospital has concentrated to an increasing extent on those aspects of a complete medical service such as cannot be secured elsewhere.

The position of the hospitals has also been affected by changes in general practice. Until quite recently there were sections of the population unable to obtain the services of a general practitioner or a family doctor. There existed under the Poor Law a system of domiciliary medical service for the destitute poor, but many declined to use this service on account of the social stigma which they felt attached to it. The lower-paid workers, too, were often unable to obtain general practitioner service owing to their inability to pay for it, and their reluctance to make use of the Poor Law service. The hospitals were the salvation of these classes, and provided a complete institutional service for this section of the community because they could not afford to obtain medical service of any kind.

The situation has now changed. Under the National Health Insurance Acts nearly twenty million persons obtain a domiciliary medical service from their own chosen medical practitioners. This two-fold development requires in the public interest that the hospital, whether voluntary or municipal, shall devote itself exclusively to that form of service which it alone can provide for the bulk of the community.

To sum up, hospitals should confine their activities to the essential services which hospitals alone can provide, insisting that all other necessary attention should be

obtained elsewhere. Out-patient departments should be consultative cent
accepting, save in emergency, only those cases recommended by their own doct

Co-operation.

Co-operation there must be, not only between the voluntary hospitals and
local authority, but between voluntary hospitals themselves. All too freque
voluntary hospitals have grown up in an atmosphere of parochialism, with
contact or co-operation with neighbouring institutions of the same kind. In s
areas there exist several voluntary hospitals, including a number of small spe
hospitals. Between these there should be unification, even if, in some cases
means absorption or combination of one or more hospitals. Such co-operation
already been secured in certain towns, notably Liverpool, Manchester, and Oxfo

In such consultations all interests should be considered, including those of
practitioner, whether general, specialist, or consultant. In some areas, lo
authorities will prefer to make substantial contributions to voluntary hospitals
the performance of certain work; in others they will prefer to make their provis
direct. No spirit of wasteful competition should appear between agencies concer
with one purpose—the provision of the necessary hospital accommodation for
area. It is legally possible to make arrangements whereby members of contribut
schemes are admitted to local authority as well as to voluntary hospitals. Bear
in mind that local authorities must charge costs, it is clear that this provision
only makes financial co-operation between the local authority, the volunt
hospital, and contributory schemes desirable, but emphasises the need for separat
contributory schemes from particular voluntary hospitals.

The Association strongly supports the recommendations in the report of t
Voluntary Hospitals Commission, published in 1937, for the regional developme
of voluntary hospitals, under the guidance of a strong, central co-ordinating bod
A regional hospital committee should co-operate with the local authorities in t
establishment of a joint hospital body or board, to secure the co-ordination
in-patient facilities, as regards admissions and necessary transfers and also of t
ambulance service in the area.

The Pay Bed.

The Association recognises that there is, in many areas, a shortage of hospit
accommodation for the people belonging to the middle classes. Although his incom
is above that accepted for hospital purposes, it is usually insufficient to cover t
cost of a privately-established nursing-home. The development therefore
pay-beds in association with hospitals at fees within the capacity of such patien
is to be welcomed. There are now in existence a number of provident associations
which enable the subscribers to insure against the contingency of illness whic
requires hospital treatment. These insurance schemes attract subscribers
moderately-priced beds, and cover, within reasonable limits, the cost of hospit
accommodation and consultant and specialist services. I feel, however, th
pay-beds in hospitals should be available to all classes of the community and th
there should be no income limit applied. The institutional and professional charge
would simply vary according to the status of the patient.

ontributory Schemes.

The Association supports the recommendations of the Voluntary Hospitals ommission on the subject of contributory schemes.

(1) Schemes should be regional in organisation and in the provision of hospital benefits.

(2) The benefits of schemes should be confined to wage-earners and others within prescribed income limits.

(3) The administration of schemes should be in the hands of a committee independent of any hospital in the area.

(4) Hospitals should be free to refuse cases unsuitable on medical grounds. Acceptances at hospital, except in an emergency, should be on the recommendation of the patient's doctor.

(5) No contributor should have preferential consideration over other patients as regards admission to hospital.

(6) Contributory scheme funds should be utilised for payment to council hospital authorities in respect of services to contributors at council hospitals.

There has been a marked tendency in recent years for the representatives of ntributory schemes on boards of management to attempt to dictate the policy voluntary hospitals and to demand that subscribers should receive preferential atment, both as regards admission to hospital and in the out-patient departments. his policy ought to be resisted vigorously by the medical staffs and by the boards management.

The attempt to include in hospital contributory schemes members whose incomes e far beyond the prescribed limit, should also be fought. Such patients can be ovided for by provident insurance, and the contracting field of private practice ould be maintained as far as possible.

luntary Hospitals.

The voluntary hospital system embodies a principle—that of voluntary service—ich is deeply ingrained in the traditions of this country. In its atmosphere of edom an efficient system of medical education has been developed, and medical earch of the highest quality has been fostered. The combined annual income all the voluntary hospitals exceeds their aggregate expenditure, though the lance of one hospital is not available to meet the deficit of another.

Whatever the modifications in form that it may undergo to meet the changing cumstances of the times, the voluntary hospital is certain to play a large part the hospital life of the country for a long time to come.

The Association recognises a dual policy regarding voluntary hospitals :—

(a) That the purely charitable side should be continued, wherein the whole cost of the patient is met by the gratuitous gifts received by the hospital and on whose behalf the services of the visiting medical staffs are given gratuitously.

(b) That patients, other than free patients, may be received for treatment at voluntary hospitals, and that for them payment should be received, either from the patients themselves or from the local authority referring them to

the hospital, and that on account of their treatment, suitable method remunerating the visiting medical staff should be arranged.

Applicants for hospital benefit, not being free patients, whose income does exceed a specified local scale, should be provided with hospital service on te appropriate to their financial position. Where such payments are in respect both maintenance and treatment, the visiting medical staff should receive from hospital authorities remuneration for their professional services by salary, honorarium, or by agreed payments, to a staff fund placed at their disposal. strictly charitable basis of the voluntary hospital exists only to the extent tha very small number of their poor patients now receive free treatment. The gr majority of persons now obtaining treatment are those who can pay, desire to p and do in fact pay, directly or indirectly, towards their maintenance and treatme Although the medical profession will gladly give its services gratuitously, as alwa to those who cannot afford to pay for them, it is inequitable to require it to g its services without remuneration to voluntary hospitals which treat patients a to pay, and which in practice collect payments amounting in the aggregate very large sums from these patients. The field of private practice has contract with the result that consultants, and particularly the young consultants, are findi it increasingly difficult to make a living.

It is in the public interest that there should be available in every area sufficie consultants and specialists to satisfy the needs of the community outside t hospitals. In the view of the Association, there should be remuneration of t medical staff in respect of all medical services in hospital for which payment made, directly or indirectly, by patient, employer, local authority, or contributo scheme.

The method of remuneration adopted in a particular hospital will depend local conditions. If the method of remuneration in relation to contributory patien is by a payment of a percentage of moneys received to a medical staff fund, th the percentage paid by a hospital with a resident medical staff should be not le than twenty per cent.

NUFFIELD PROVINCIAL HOSPITALS TRUST.

Co-ordination of Hospital Services.

The question how best adequate hospital facilities could be provided has exercise the minds of many during the past few years. It has also occupied the attenti of numerous committees, both official and unofficial. For a long time little progre was made because there was a pronounced cleavage of opinion between those, o the one hand, who saw a co-ordinated state hospital as the only effective remed for the admitted chaos, and those, on the other hand, who knew our great voluntar teaching hospitals, had seen the strides in medicine and surgery for which the organisation had provided facilities, and who could not regard their passing a anything but a calamity. From this clash of ideas gradually emerged a plan fo the regionalisation of hospital services, a plan which provides for the ordere

development of both the existing types of hospital within the framework of an area organisation upon which all hospital and kindred interests would be represented.

Hospital regionalisation as a method of providing an efficient hospital system was first put forward with authority by the Sankey report, which is a report of the Voluntary Hospitals Commission of the British Hospitals Association. This Commission sat under the chairmanship of Lord Sankey and reported in 1937. The principal recommendation of this report was in three parts :—

(*a*) The division of the country into hospital regions.

(*b*) The formation of Regional Councils, and

(*c*) The formation of a Central Hospitals Council to co-ordinate the work of the regional councils.

Although the terms of reference of the Commission limited their findings to voluntary hospitals, they did nevertheless advise that local authorities should be asked to collaborate in the work of the regional councils.

With the setting up of the Emergency Hospital Service public recognition was given to one of the principles enumerated in the Sankey Report, viz., that all the hospitals in each natural service region should co-operate, and that county boundaries did not represent the natural and convenient limits of such regions. The Emergency Hospital Plan for war services was necessarily largely imposed by the State, and has seriously limited the effective control both of voluntary hospital boards and of local authorities over their own hospitals.

It is inconceivable that, after the war, we could return to the haphazard pre-war hospital arrangements, and some form of planned hospital system is inevitable. The choice, therefore, is between a State hospital service perpetuating the main features of the Emergency Hospital Service, and an alternative scheme of regionalisation based on voluntary co-operation in regional and divisional councils, in which the local authorities and the voluntary hospitals would be partners. The encouragement of such a scheme is the primary task of the Nuffield Provincial Hospitals Trust.

In November, 1939, Lord Nuffield, appreciating the desirability of proceeding with the regional organisation of hospital services in Great Britain and Northern Ireland, created the Nuffield Provincial Hospitals Trust with an initial donation of one million shares in Morris Motors Ltd., valued at £1,250,000.

What is Hospital Regionalisation?

In general terms, hospital regionalisation may be explained as the voluntary co-operation of all hospital and kindred services organised in areas separated by natural rather than by artificial administrative boundaries.

The key hospital of a region, wherever possible, will be a hospital associated with a university medical school.

The centre of the hospital organisation in the divisions will be a large hospital possessing facilities for diagnosis and treatment of most types of disease, to which the other hospitals in the division can refer cases of special difficulty and which can in turn refer patients back to the smaller local hospitals when adequate

facilities for a particular case are available there. This is one instance of the
in which co-operation can help. Other examples can be given. For exampl
region or division may expect to be able to provide adequate and efficient pa
logical and other laboratory services for the benefit of all participating hospit
and eventually for all medical practitioners. And again, the divisional organisa
will, in many cases, make available for the small hospitals the services
consultants and specialists attached to the key hospital. Indeed, it may
happen that, alternately, a system will be evolved whereby some consultants
specialists will be appointed to a region or division rather than to a single hospi

A National Hospitals Board or Council.

When regional organisations have been established, it is intended that t
should nominate representatives to a National Hospitals Council; a body,
functions of which would include the co-ordination of hospital services throughe
the country, and liaison with Government departments.

Functions of the Nuffield Provincial Hospitals Trust.

It will be appreciated that the Trust has not been formed to undertake region
sation of hospitals in any particular area, but to encourage and support that wo
where invited to do so. It will have at its disposal an income of about one hundr
thousand pounds per annum, which it is hoped to augment by donations from oth
supporters of the hospital services.

Medical Advisory Council of the Trust.

Administrative reconstruction is not enough. The ultimate problem of t
hospital service of the country, even when properly organised, with all hospita
working in co-operation, must be concerned with the treatment of the sick—
essentially a medical problem. The trustees have, therefore, set up a Medic
Advisory Council, comprising representative leaders of the medical profession unde
the chairmanship of Sir Farquhar Buzzard. This Council has been in touch wit
medical faculties and public medical officers in all the chief centres of population.

Conditions arising out of the war have necessarily affected the activities of th
Trust. In some areas war conditions have made it impossible to organis
conferences, while in others there has been some disinclination to proceed activel
with the co-ordination of the hospital services during the war. On the other hand
there has been, in many provincial areas, a realisation that economic condition
and service requirements are undergoing considerable transition as a result o
the war, and this has stimulated interest in the scheme for the regionalisation o
hospital services which is being developed by the Trust.

Already conferences have been held at Bristol, Edinburgh, Guildford, Leeds
Liverpool, Manchester, Newcastle, Plymouth, Sheffield, and Truro. Thes
conferences were attended by representatives of voluntary hospitals and loca
authorities, and the regionalisation scheme was approved on each occasion. I
Scotland, an Advisory Committee on the Regionalisation of Hospital Services ha
been formed, and some useful progress has been made.

Northern Ireland has been visited twice by the chairman of the Regionalisation uncil (Mr. S. P. Richardson) and the chairman of the Medical Advisory Council r Farquhar Buzzard), and their visits have stimulated interest in the scheme of ionalisation for hospitals in Northern Ireland.

Only last week a further meeting representing the hospitals was addressed by . Richardson, and the Vice-Chancellor was empowered to co-opt a committee draw up tentative plans for the regionalisation of hospitals in Northern Ireland.

WHITHER MEDICINE?

PREPARED BY A COMMITTEE OF THE SOCIALIST MEDICAL ASSOCIATION.

December, 1939.

a synopsis of present systems and future plans, there is a short account given the present position and future requirements of the nation.

It is maintained that under the present system of private practice the general ctitioner suffers many disadvantages, of which the chief professional defects are :

Lack of specialist facilities for all his patients;
Separation from the hospitals and clinics;
Inability to follow up his cases when admitted to hospitals;
Lack of guidance on new therapeutic measures.

It is proposed to remedy this state of affairs by dividing the whole country up o regions, which may include a number of existing local authorities and in ich hospitals, personnel, etc., will be pooled for the common use of the whole ion. Hospital centres may require to be established according to transport ilities, and uneven distribution must be smoothed out. Subsidiary clinics will grouped around the larger hospitals, and from these domiciliary services of tors, nurses, midwives, health visitors, etc., will operate, while at the clinics oratory, radiological, and other consultant services will be available. The ncial burden will be divided between insurance contributions, rates and taxes, many feel that health is a national asset and that the medical services should a national responsibility, of which the main cost is borne by taxation.

e Lancet's Plan for Hospitals.

n October, 1939, stimulated by the changes produced by the Emergency dical Service, The Lancet published "A Plan for British Hospitals."

The scheme is based on the Ministry of Health's Emergency Hospital Service visualises a regional co-ordination of all hospitals, preserving certain features the voluntary system, such as medical control by a medical committee and a tem of staff firms, combined with the decentralisation and regionalisation which racterise the Emergency Medical Service. Since decentralisation makes Harley eet practice an impossibility, all staffs would require to be on a full-time basis.

A new idea in The Lancet plan is, that the control of the hospitals should not in the hands of the Ministry of Health, but in those of a new organisation, National Hospital Corporation, controlled by a board of governors, of whom at

least one-third should be doctors. This Corporation would be appointed c
charter to be reviewed by Parliament every five years, and it would take ove
hospitals, voluntary and municipal. This would include all hospital endowme
investments, site values, etc., but the Corporation would also require a Governm
loan to finance developments.

Current expenditure would be met by patients' contributions, provident sche
direct taxation, or compulsory hospital insurance.

HOSPITALS IN WAR-TIME.

BRITAIN entered the present war with over three thousand hospitals and no hosp
system. There were not even two hospital systems, one for voluntary and one
municipal hospitals. The thousand or more voluntary hospitals were a
administered, somewhat jealous of their independent status, and only very loos
associated with one another. The municipal hospitals were controlled by hundr
of individual local authorities under the remote supervision of the Ministry
Health and the Department of Health for Scotland.

A similar state of things existed in Northern Ireland except that, in addition
voluntary and municipal hospitals, there were other hospitals partly volunt
and partly subsidised.

In the absence of any unified hospital system, the threat of war and all that
was thought to imply in terms of civilian as well as military casualties, made
imperative for the Government to take a hand in hospital planning. The res
has been the Emergency Hospital Scheme and the Emergency Medical Servi
Viewed against the background of pre-war hospital organisation, the scheme mu
be regarded as a considerable achievement in improvisation, but it cannot be tak
as a model for post-war organisation. Amended and improved in certain respect
it should continue to serve reasonably well under the exceptional circumstanc
of war-time, while in the post-war world, some of its features may well serve
a starting point for more far-reaching reforms.

The bombing plane, by transforming the nature of warfare, has forced on
the transformation of our medical services. Air-raids have compelled us to crea
a system of casualty services for the rescue and immediate aid of air-raid victim
and to reorganise the hospital services for their effective treatment. For casualti
requiring hospital treatment an Emergency Hospital Scheme has been brough
into being in England and Wales with 225,000 casualty beds, staffed by ov
1,700 full-time doctors, with 5,150 other doctors on call for work when needed
This work cost £15,700,000 in 1940-41. The first attempt at national hospit
planning was the inevitable result of three facts:—

(1) That an unco-ordinated hospital system could never have stood the strai
of Nazi bombing.

(2) That hospital services had to be largely removed from towns into the countr
areas, where patients can be treated without constant fear of bombs.

(3) That the Government rightly decided that "cases of injury or illness attributable to, or connected with, war operations must be a charge on national funds."

Pre-war estimates expected anything from 30,000 to 150,000 casualties, following e big air-raid, and the Ministry of Health planned to make 300,000 beds available the outbreak of war for civilian and service casualties. Britain's public and ivate hospitals contained at most 567,000 beds (153,000 in mental institutions), e great proportion of which were in target areas. Outside the large towns in ngland and Wales some two hundred institutions, mainly public assistance stitutions, mental and fever hospitals or sanatoria, were "upgraded" at a cost £750,000 into hospitals capable of first-class work, by the provision of operating eatres, x-ray apparatus, laboratories, etc. These upgraded hospitals had 64,000 w casualty beds.

At the outbreak of war, 100,000 patients were discharged, and 71,000 beds out 98,000 in the London area were reserved for Emergency Medical Service cases. most large towns there were not enough beds to make any reduction possible, e peace-time supply being so inadequate that more beds had to be provided r casualties.

From August, 1940, to May, 1941, when air-raids occurred night after night, e scheme only began to work efficiently after many weeks, and the organisation d not stand up to the test of bombing as well as the personnel. The number of sualties never approached the figures expected, and the peak of 7,500 civilian sualties in Emergency Medical Service beds in November, 1940, was never ceeded.

There have been many special services established in connection with the mergency Hospital Scheme. There are nine centres for neurosis, ten neuro-rgical units, ten maxillo-facial, and nine chest centres. Children's units have so been formed in all the London sectors, while the Medical Research Council s established an emergency public health laboratory service to facilitate early agnosis of infectious diseases and to distribute vaccines and sera. There are any laboratories throughout the country, and the central laboratories in Oxford, mbridge, and Cardiff are controlled by the Medical Research Council. Since ly, 1940, the Ministry of Health has built up the blood transfusion service into national scheme, each region having its own service. Serious fractures are ated at twenty Emergency Medical Service centres in Britain and six in Scotland. ch has a physio-therapy department and facilities for remedial games and cupational therapy.

The outstanding merit of the Emergency Medical Service is that it has begun process which total war makes absolutely imperative: a pooling and reasonable tribution of medical resources and scientific skill. A planned system of special atment centres and pathology services is coming into being in every region the country. Attempts are being made to move surgeons, specialists, and search workers around as required. As a result, patients everywhere have a

better chance of first-class treatment, and the special centres provide opportun for improvement in medical knowledge and skill.

The Emergency Medical Service in Northern Ireland is under the contro the Ministry of Home Affairs and directed by the Hospital Officer, who is the Ministry's permanent staff. Three assistant hospital officers resident in north-western, western, and southern areas of the country are responsible to Hospital Officer for a certain number of hospitals in their districts. All hospi in the Emergency Hospital Scheme retain their pre-war standard of s government.

Considerable expansion has been necessary and is still being planned to m current and potential demands for accommodation. In peace-time the total num of beds in voluntary, district, county, and cottage hospitals and union infirma was 5,337, and an additional 1,557 beds have already been installed. A furt plan whereby 2,125 extra beds will be made available for hospital purposes is active contemplation. With this increase in bed capacity, extensive up-grad has been carried out and a large amount of equipment has been provid Emergency theatre equipment has been supplied to some hospitals, and porta x-ray units have been established. It has also been necessary to undertake prot tive works in hospitals, which have benefited by the advice of the Ministr architects as to the best means of guarding against injuries from blast and gl among patients and staff; and the fire-fighting facilities of hospitals have a received careful attention. A fleet of bus - ambulances has been acquired f transferring casualties from urban to rural hospitals and for the evacuation convalescent casualties, and aged and infirm patients, to the centres which ha been established. Those hospitals undertaking casualty work are paid in f according to their individual cost of maintenance.

Each hospital has its roll of Emergency Medical Service members attached f the treatment of casualties, and in all there are 242 members of the Service Northern Ireland. Recognised consultants can be called to any hospital in t scheme, and, in addition, there are five Mobile Surgical Teams ready to opera where they are most urgently required. There are no salaried appointments the Emergency Medical Service, members being paid on a capitation basis an consultants on a sessional basis.

An agreement between the civil and military authorities allows the military t take advantage of civil hospitals in appropriate areas, and urgent cases can b treated there. Service medical officers may also avail themselves of members the Emergency Medical Service in a consultant capacity.

An Emergency Blood Transfusion Service has been organised, and its function are divided into two regions, each having its own panel of blood-donors. Casualty receiving hospitals have been provided with refrigerators to hold a supply o blood-plasma, while sub-depots of plasma are also established at selected point for emergency use. The bleeding and typing of donors is being carried o unceasingly, and increasing stocks of whole blood and plasma are becomin available.

To assist in hospitals where heavy demands are made upon the nursing staff, the Civil Nursing Reserve has been established, consisting of part-time and whole-time volunteers. These nurses can be called upon by any hospital, and the terms of service are on the same lines as in Great Britain. The Civil Nursing Reserve has become increasingly useful to hospitals since the term "casualty"—originally defined as "air-raid casualty"—has been accommodated to include many other categories.

Gas-cleansing units have been established at selected hospitals in provincial towns, a member of the Emergency Medical Service taking charge as gas officer. The established nursing staff is reinforced by members of the Civil Nursing Reserve for the working of the unit. A complete service in relation to gas warfare has come into being by the appointment of a clinical consultant to work in co-operation with a pathologist and gas identification officer, whereby contact with the authorities in Great Britain and with the military authorities is easily available.

Government Policy.

The latest statement on the future of hospitals has just been made recently in Parliament by the Minister of Health, Mr. Ernest Brown. According to "The Times" of 10th October, 1941, he stated: "It is the objective of the Government as soon as may be after the war, to ensure that by means of a comprehensive hospital policy, appropriate treatment should be readily available to every person in need of it. It is accordingly proposed to lay on the major local authorities the duty of securing, in close co-operation with the voluntary agencies working in the same field, the provision of such a service by placing on a more regular footing the partnership between the local authorities and the voluntary hospitals on which the present hospital services depend. The Government recognise that to achieve the best results and to avoid a wasteful duplication of accommodation and equipment, it will be necessary to design such a service by reference to areas substantially larger than those of individual local authorities." On the financial aspect the Minister continues: "It is the intention of the Government to maintain the principle that, in general, patients should be called upon to make a reasonable payment towards the cost, whether through contributory schemes or otherwise. In so far as any new burden may be thrown upon local authorities in providing and maintaining hospital accommodation or in contributing towards the expenditure of voluntary hospitals, a financial contribution, the extent of which will be a matter for further consideration, will be made available from the Exchequer. Special arrangements for dealing with the teaching hospitals by way of increased educational grants are in contemplation." He then stated that he was instituting a survey of hospitals in London and the surrounding area to provide information for future planning, and he referred to the admirable preliminary work of the Nuffield Provincial Hospitals Trust in the provinces.

The substance of these remarks seems to be that the Government in Great Britain visualise a post-war hospital service planned on a regional scale, in which both voluntary and municipal hospitals will play their part. He states that financial

assistance will be given to voluntary hospitals by local authorities. And, fina
he commits local authorities to bearing the financial burden of the scheme, w
Government will make a grant from the Treasury to local authorities, the ext
of which might well vary between one per cent. and one hundred per cent.
the cost of the hospitals. This is scarcely satisfactory, but it gives offi
recognition to the value of the work of the voluntary hospitals and expresses
hope that a partnership between the voluntary and municipal hospitals may re
in an efficient hospital service for all who need it.

It is scarcely necessary to remind a medical audience that health affairs
Northern Ireland are divided between the Ministries of Home Affairs, Labo
Education, and Public Security, without any co-ordinating authority, such as
Ministry of Health in England and the Department of Health in Scotland. T
there is no central authority for public health affairs is not only regrettable, b
has resulted in an overlapping of various health services, and a lack of c
ordination between the various ministries responsible.

Reasearch in agriculture has been subsidised by the Government for many yea
but, so far as I am aware, not a penny has been spent in medical research, wh
the only Government grant to a teaching hospital has been for the training
midwives.

It seems to me that the time is long overdue for the establishment of
Department of Health for Northern Ireland, with a Government official of at lea
the status of a Parliamentary Secretary in charge. This Department should b
entrusted with all the health services and should, in co-operation with the medic
profession, make plans for a comprehensive and complete regional health servic
in the immediate post-war period. Nothing less will be effective in dealing wit
the present chaotic condition of affairs, and it will require a central Governmen
department to initiate and co-ordinate the regional organisation of a comprehensiv
hospital policy.

On the purely medical side, I should like to mention briefly certain problem
with which we must deal ourselves in order to supply a better hospital service.

Fractures.

Fracture clinics have come into favour at many hospitals in Britain, and in 193
the British Medical Association instituted a report on fractures, which criticise
the unsatisfactory proportion of cures at a large number of hospitals, as compare
with organised fracture clinics. The opinion of surgeons seems to be divided o
this point. My own view is that the poor results are the outcome of dischargin
fracture cases from hospitals just at the time when they need help and instructio
most. These cases require re-education in the use of their injured limbs, and th
establishment of physio-therapy departments where remedial exercises and occupa
tional therapy under a surgeon should be carried out would revolutionise th
results. This work could best be organised on a regional basis.

There are a number of large medical problems which at present await a satisfactory solution. These include the establishment of a centre for orthopædics in Northern Ireland, though a beginning has already been made.

Northern Ireland is the only part of Great Britain which has not yet instituted special cancer services on a regional basis. This problem was considered by certain members of the Government as long ago as 1929, but so far no active steps have been taken to secure adequate facilities for the treatment of this ubiquitous disease.

The treatment of both pulmonary and surgical tuberculosis should also be established on a regional basis, with large central country hospitals where all cases could be treated. The haphazard treatment of small numbers of patients in isolated districts should be abandoned.

Chest and brain surgery are very special fields of surgery and should be dealt with by well-organised teams working in a central hospital, to which all such cases should be transferred.

Plans should also be made to provide accommodation in a convalescent home or homes for aged and infirm people who are not seriously ill, but who cannot be looked after in their own homes, or who have no home. The workhouses are not a solution of this problem, nor are they suitable for the reception of cases of incurable disease, which cannot be kept in the general hospitals.

Medical Teaching.

In Northern Ireland the teaching of medical students has been completely ignored by the Government. In spite of official indifference the medical school continues to flourish, but if we are to keep the best of our young graduates at home, it would seem essential that more full-time teaching appointments, both in the University and the hospitals, must be provided. Such posts would enable young men to earn a living while engaged in post-graduate study and research, and would tide them over that difficult period before they can make progress in their chosen branch of the profession.

A medical school and its hospital will eventually die unless research is kept alive and the younger men encouraged to enter this field. I believe it would also be a great advance to appoint certain of the younger consultants and specialists on a whole-time basis to a group of district hospitals, where their work would be valuable and where they would gain experience and knowledge, while helping to raise the general standards of professional efficiency throughout the country. This plan has already achieved much success in Great Britain under the Emergency Medical Service scheme.

Hospital Staffs.

I should like to add a word regarding the position of nurses and permanent staffs of hospitals. It seems to be a recognised procedure in voluntary hospitals to pay the nursing and lay staffs the minimum. While realising that money publicly subscribed must not be wasted, I consider that the permanent staffs

of hospitals are, as a rule, grossly under-paid for the work they perform. S
improvement has come about in Great Britain as a result of the war, but so
the new scale of nurses' salaries has not been applied to Northern Ireland. W
Trades Unions demand and receive higher wages and war bonuses, hosp
personnel are expected to acquiesce in receiving the same pay as in pre-war d
regardless of the rise in the cost of living. Pension schemes for all hosp
employees should be compulsory, and nurses' pension schemes should be lin
up with these in Great Britain. I hope that something will be done to impr
the conditions of a most loyal and industrious body of men and women wh
great services are too seldom recognised.

Out-Patient Department.

The types of cases for which the out-patient department should properly
utilised fall into three groups :—

(1) Casualty cases.
(2) Consultation cases, including those retained for special treatment.
(3) Discharged in-patients.

Casualty Cases.

These include accidents and sudden emergencies. The hospital would not
fulfilling one of its main functions if these patients did not receive prompt attenti
without question. After the first attendance, however, further treatment in
out-patient department should not be given unless such treatment is not availa
elsewhere. If not admitted to the hospital, the patient should be referred to
usual medical attendant.

Consultation Cases.

The main function of the out-patient department should be consultation.
patient, other than an emergency case or a discharged in-patient, should
accepted for consultation or treatment without an accompanying letter from
general practitioner. In many instances all that is necessary is a single consu
tation, the patient being referred back to the practitioner with a letter from t
member of staff of the hospital. Admission to the beds of the hospital will
necessary in some cases. Others requiring some prolonged special treatme
which the patient is unable to obtain elsewhere, will continue attendance at t
hospital.

Discharged In-Patients.

Discharged in-patients may require periodic inspection or treatment, whi
should be continued at the out-patient department or special department.

It frequently happens that such discharged patients continue to haunt the ou
patient and special departments for a time, which cannot be justified either o
medical or economic grounds.

Unsuitable Cases.

There is a fourth category for which hospitals should not be called upon
make provision, namely, the patient who comes, with or without a doctor's lett
suffering from some minor or chronic ordinary ailment, the treatment of whi

would normally be undertaken by a general practitioner. This is the type of case which is responsible for many of the unjustifiable demands made upon the services of medical staffs. The patient should be examined, but no treatment should be given unless it is not available elsewhere. The growth of contributory schemes has been largely responsible for aggravating the misuse of out-patient departments. The British Hospitals Contributory Schemes Association definitely recommends that a person is entitled to out-patient benefit only when, in the view of the medical staff of the hospital, his condition demands it.

Although it has been made clear that members ought not to expect services from out-patient departments, the public has been slow to realise that the out-patient departments are complementary to, and not a substitute for, the medical care obtainable from private practitioners.

It would appear obvious that reform of the out-patient department is urgently needed. The department can be made much more useful to the community by treating it, not as a place for the encouragement of a miscellaneous crowd of chronic patients, but as a consultative department for the provision of a second opinion after a careful examination and diagnosis by the patient's own doctor, and for the provision of specialised treatment.

Nursing Services and Technical Staffs.

Nursing has now become a highly skilled profession demanding high standards of character and intellect. For years there has been a serious shortage of trained nurses, partly because of the unsatisfactory arrangements for training, combined with disgracefully long hours, low pay, bad working conditions, and excessive interference with personal liberty, which the present system frequently entails.

Nurses are obliged to do a great deal of heavy domestic work, which is unessential for their training and would much better be left to ward maids.

If the right type of educated candidate is to be attracted to the profession, measures must be taken to pay salaries commensurate with the importance of the work and to give conditions of service allowing much more leisure and freedom. A step in the right direction has been taken by some hospitals by the erection of good nurses' homes containing comfortable reading and recreation rooms, but much still remains to be done.

The status of the profession should be recognised by the State as of outstanding importance, and made comparable to that of the teaching profession, while the salaries and pensions of nurses should be arranged on a national basis. Shorter working hours should be introduced and four weeks holiday granted yearly.

The technical staffs of hospitals have also suffered much hardship in the past, on the apparent assumption that voluntary hospitals should pay their technicians the lowest possible wages. Radiographers, laboratory workers, engineers, and pharmaceutical chemists should receive much greater consideration than they do at present, while their wages and pension rights should be made secure.

Far too little consideration is given, as a rule, by boards of management to t nursing and technical staffs, and it is not realised that on the loyal and wh hearted co-operation of these devoted servants of the hospitals the real succes the hospitals depends.

Hospital Almoners.

I should like to refer to hospital almoners, as their work seems to be li understood or appreciated even by the medical profession, and they will conti to play an increasingly important part in the hospital system. Almoners consti the link between the hospital and the patients. Apart from their function preventing hospital abuse, they are responsible for arranging convalescent other follow-up services, such as the supply of special instruments and diets. T often intervene in the home-life of patients and induce them to come to hospit They put patients in touch with charitable organisations where necessary, can give the medical staff very useful information on the patients' backgrounds.

In short, the almoner is the hospitals' liaison officer with the public and w the public health, schools, and public assistance authorities. The appointment further almoners in all voluntary hospitals should be encouraged. They are highly-trained women, most of them with university degrees.

Hospital Records and Follow-up System.

One of our greatest needs at the present time is an adequate follow-up syste by means of which patients can be found at any time and brought back to hospit for further investigation or treatment. Certain continental centres, notably Swede have brought this service to a fine art, and there is no doubt of the great ga which is derived from such a system. Adequate records of patients can be ke for years, and the success or failure of any particular form of treatment can b thoroughly tested. Such a service could well be carried out by the hospit almoners in conjunction with the Women's Voluntary Services, who intend t keep going after the war in order to devote their time to social service. At th same time much greater clerical assistance is needed both in the wards and out patient departments of all our hospitals, to keep full and comprehensive notes an records of each patient with a modern filing system for easy reference.

In this brief survey I have endeavoured to indicate the trend of hospital polic after the war, and some of the official and unofficial opinions which have bee expressed to date. With the raising of the Medical Health Insurance maximum income from £250 per annum to £420 per annum, a very large percentage of th whole population will now come under the panel system and will expect to b eligible for hospital contributory schemes. This will generally narrow the fiel for general practitioners and consultants alike, particularly in Northern Ireland and will bring about a large increase in the demand for hospital beds. With th present rate of taxation, which is likely to continue for many years to come, i appears certain that charitable bequests and subscriptions to voluntary hospital will gradually diminish, as they have already done in the past twenty years. An yet, in spite of the inevitable changes which have and will continue to take place

I still believe there is a great future for the voluntary hospitals. The voluntary system is deeply ingrained in British hospital tradition, and it commands a great deal of voluntary effort of great value. It has the flexibility and the atmosphere of freedom in which medical education and medical research flourish, and patients are taken in from any part of the country, irrespective of county or local government boundaries. It would be nothing short of a tragedy if the voluntary hospitals, as such, were to disappear into the limbo of forgotten things, and their fine traditions of voluntary service lost in state-controlled institutions.

In conclusion, may I say that health services, to be effective, must not concentrate solely on curative work. In the past we have perhaps been too much occupied with salvage work, and have not concentrated enough on the large task of boldly creating conditions in which a healthy people can flourish.

The important point is for positive health services to grow up, by the provision of more and better food, housing, recreation, and social and economic security, and then our attitude of conferring the term "health services" on what are really "sickness services" will be left behind.

Basically, health is a problem of education, and it is only through the distribution of knowledge that we shall ever achieve the fitness to which a great people should aspire.

Postscript.

Since the above address was delivered just a year ago, a good deal has happened which justifies the belief that certain of the lines of development indicated in this paper are likely to be put into effect after the war. In the first place, it would appear that the Interdepartmental Committee, under the chairmanship of Sir William Beveridge, has been charged with the duty of examining and advising as to the possibility of a comprehensive State scheme of social insurance, and it is undoubtedly probable that pressure for the inclusion of specialists and hospital treatment will be exerted. This would mean, in effect, compulsory insurance for hospital and specialist services on the same basis as National Health Insurance, and would introduce the State control of hospitals. Certain factors, such as the cost, may be advanced against the possibility of such a scheme, but it would appear essential that some reasonable alternative scheme should be evolved in the near future, on a voluntary basis, if the voluntary hospitals, as we know them, are to retain their present position of eminence in the nation's hospital system.

Secondly, there has recently been formed in Northern Ireland a Regional Hospitals Council under the auspices of the Nuffield Provincial Hospitals Trust. This Northern Ireland Council is representative of all the hospitals in the area: voluntary, district, municipal, and special hospitals. The Vice-Chancellor of the Queen's University is its chairman, and it has as its main objectives the survey and co-ordination of hospital and auxiliary services, the promotion of such legislation as is likely to improve these Services, as well as the consultation on all matters of common interest among all hospital authorities. Its fundamental purpose is to

aim at raising in every possible way the standard of service to the patient throughou the region, and to encourage and initiate research on the detection, prevention, an treatment of disease.

It would seem that a great step forward has been made in the attempt to g all types of hospital working harmoniously together, and with good-will and co operation many of the hospital problems which have been referred to in this addre may be speedily solved.

We feel that a special word of praise is due to the Vice-Chancellor for h foresight and vision in bringing about the formation of this Council, and we hop that all his expectations for its success may be more than fulfilled.

Finally, a Northern Ireland branch of the British Hospitals Association has bee formed within recent months. This Association deals only with voluntary hospitals and it is very satisfactory to note that practically every voluntary hospital in th area has joined.

While more limited in scope than the Regional Hospitals Council, there ar nevertheless many special problems affecting voluntary hospitals in the area wit which this Association can deal, and already the question of nurses' salaries ha been discussed with the Ministry of Home Affairs. The Association hopes t maintain close relations with the Regional Hospitals Council and, jointly, to assi in promoting the best interests of all hospitals and their work for the community.

There are some who deride every attempt at advance in social betterment an in the establishment of a better hospital service in Northern Ireland, and wh wilfully refuse to admit the profound changes which have already taken place i the social and economic life of this country. Greater changes still are in the making and it is our duty to attempt to erect a better and more stable structure on the old and to secure for everyone, and particularly for those in the services, a much bette and more comprehensive hospital service. We must also work to establish an assured position for our service colleagues, who will provide the hospitals with their consultants and specialists after the war.

REVIEW

MEDICAL JURISPRUDENCE AND TOXICOLOGY (Seventh Edition). By John Glaister, M.D., D.Sc. Pp. 671, with 132 illustrations, several in colour. E. & S. Livingstone, Edinburgh. Price 28s. net.

It is now forty years since we welcomed the original appearance of this work. During that time it has undergone many changes, but at no time has it been more suitable for a student's textbook than in the present edition. Much of the inevitable minor detail which had crept in with the various revisions has been pruned down, and the illustrative cases have a more modern ring. Bibliographical references now appear at the end of each chapter, instead of as footnotes, and the small-print insertions of previous editions have disappeared, so that reading is more easy.

Whilst references to legislation have been brought up to date, and small print eliminated, the book is actually seventy pages shorter than the previous edition. Once again we must congratulate the publishers on the way in which they have overcome their difficulties and have presented us with a volume worthy of their efforts in peace-time.